

DREAM Atlanta
DIABETES / HYPERTENSION 1-on-1 IN-PERSON VISIT #1

PARTICIPANT UID: _____

CHW NAME: _____	CLINIC SITE: _____
ONE-ON-ONE DATE: _____ / _____ / _____ MM DD YYYY	

ENCOUNTER TYPE: ☐ By Phone ☐ In-Person

FOLLOW-UP ON CURRENT SHORT-TERM ACTION PLAN

REVIEW CURRENT PLAN WITH PARTICIPANT → *Review the current plan (from most recent follow-up):*

1. How did it go with your plan? *[Recognize success/partial success; trouble-shoot barriers below.]*

Check one: ☐ **Success** – Participant completed or exceeded the plan *[Go to question 3]*

☐ **Partial Success** – Participant completed the plan in part *[Go to question 2.a]*

☐ **No Success/ Did Not Try** – Participant did not complete any part of the plan *[Go to question 2.a]*

2.a. [If last plan was “Partial Success” or “No Success/Did Not Try”]: What challenge/s you are facing?

(check all that apply)

☐ Plan was too hard

☐ Own illness/injury/pain

☐ Weather related

☐ Other: _____

☐ Lack of time / Conflicted with schedule

2.b. Describe the solutions discussed with the participant to address each challenge faced.

1. _____
2. _____
3. _____
4. _____

3. How has your weight and blood pressure been? Let’s take some measurements:

BP: ____/____ ____/____ ____/____

Weight: _____ lbs

DEVELOPMENT OF NEW SHORT-TERM ACTION PLAN

Strategies (See guidance corresponding to participant's level of success with current plan:)

- ☐ **Success** – Great job with your last plan! Let's create a new plan for the next two weeks. What do you think about making some changes to be even healthier? (e.g. Adding more vegetables and/or whole grains to your diet / Exercising more days per week and/or for longer each time)
- ☐ **Partial Success** – Good try with your last plan. Let's create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? (Re-work plan to address barriers)
- ☐ **No Success/ Did Not Try** – I'm sorry it didn't work out with your last plan. Let's create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? (Re-work plan to address barriers)

4.a. Over the next 2 weeks, the participant selected to focus on:

- ☐ Eat a healthy diet
- ☐ Be physically active
- ☐ Quit or reduce smoking, tobacco, or alcohol: Quit or reduce to: _____ per [choose:] day / week
number cig/times/drink(s)
- ☐ Manage stress

4.b. Record of Participant Plan:

What I will do (e.g. go for a 15 minute walk), if previous goal was physical activity-related, suggest increasing physical activity time:

When I will do it (e.g. in the morning after breakfast): _____

Where I will do it (e.g. around the block): _____

How often I will do it (e.g. M, W, F): _____

What might get in the way of my plan (e.g. too cold outside): _____

What I can do about it (e.g. use the treadmill in the community center): _____

Participant's Confidence Level in Reaching Goal: _____ [fill in the number that participant selected,
0 (not at all) – 10 (totally confident)]

[Note: Use Brief Action Planning Guide to revise Participant Plan until confidence is **greater than 7.**]

DIABETES MANAGEMENT

5. It is recommended that you see these specialists at least once a year. When was the last time you went to see a referred specialist regarding managing your diabetes?

Specialist	a. Did you ever see this specialist:			b. If yes, approximate month and year of most recent visit
	Yes	No	Don't know/ Not sure	
5.1 Eye				
5.2 Kidney				
5.3 Dentist				
5.4 Other				

6. Do you need a referral for a specialist?

- ☐ Yes – if yes, which specialist? _____
- ☐ No

MEDICATION ADHERENCE

7a. Did the participant bring their medications with them today? (or medication labels/photos of labels)

☐ No (skip to question 8)

☐ Yes

7b. Did the CHW review medications/insulin injections with the participant? ☐ Yes ☐ No

8. Did the participant report any challenges with medication adherence? (select all that apply)

☐ No challenges

☐ Makes me feel sick /side effects

☐ Don't need it /feel fine

☐ Can't understand/read label

☐ Too complicated

☐ Embarrassed

☐ Too expensive

☐ Other: _____

☐ Trouble remembering

9. Did the participant report doing any of the following: (select all that apply)

☐ Skipping doses when feeling fine

☐ Sharing medication with others

☐ Adjusting doses

☐ None of the above

CHW Reviews Page 3 of the "Taking Your Medicine" Booklet with the participant.

10. What recommendations did the CHW make to the participant? (select all that apply)

☐ Do not skip or stop taking medicine on your own – Take as directed

☐ Do not lower dose on your own – Take as directed

☐ Do not share medication

☐ Talk to doctor about side effects, adjusting dosage, or other concerns about medication

☐ Take your medication at the same time every day

☐ Use a pillbox

☐ Ask doctor if there are lower-cost generic options

☐ Find out about refill options

☐ Have a healthy diet and regular physical activity to help medication work better

☐ Other: _____

☐ No recommendations made.

CHW says: I am going to ask you a few questions about cigarettes, tobacco, and alcohol, which are important for managing diabetes and high blood pressure.

11a. Have you smoked at least 100 cigarettes in your entire life?

- | | |
|--|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know / Not sure |
| <input type="checkbox"/> No [Skip to 12] | <input type="checkbox"/> Refused |

11b. Do you now smoke cigarettes every day, some days, or not at all?

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Every day | <input type="checkbox"/> Don't know / Not sure |
| <input type="checkbox"/> Some days | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Not at all | |

12a. Have you ever chewed paan, paan masala, zarda, kathi or supari in your entire life, with or without tobacco?

- | | |
|--|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know / Not sure |
| <input type="checkbox"/> No [SKIP to 13] | <input type="checkbox"/> Refused |

12b. If you do use these, how often do you use them?

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Every day | <input type="checkbox"/> Don't know / Not sure |
| <input type="checkbox"/> Some days | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Not at all | |

13. During the past 30 days, how many days per week or month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

____ Days per week

____ Days in past 30 days

- ☐ No drinks in past 30 days or non-drinker
☐ Don't Know / Not sure
☐ Refused

FOLLOW-UP ON PREVIOUS SERVICES

14a. Were you previously referred to a service by a CHW? ☐ Yes ☐ No **(go to question 17)**

14b. List service 1 _____

14c. Were you able to access [service 1]?

- ☐ Yes
- ☐ No – b. If no, what were the reasons for not following through with referred service?
- | | |
|--|--|
| <input type="checkbox"/> Too far | <input type="checkbox"/> Lack of time |
| <input type="checkbox"/> Transportation issues | <input type="checkbox"/> Service no longer wanted/needed |
| <input type="checkbox"/> Do not trust service provider | <input type="checkbox"/> Other (Describe): _____ |
- ☐ N/A

15a. Were you previously referred to another service by a CHW? ☐ Yes ☐ No (go to question 17)

15b. List service 2 _____

15c. Were you able to access [service 2]?

- ☐ Yes
- ☐ No – b. If no, what were the reasons for not following through with referred service?
- | | |
|--|--|
| <input type="checkbox"/> Too far | <input type="checkbox"/> Lack of time |
| <input type="checkbox"/> Transportation issues | <input type="checkbox"/> Service no longer wanted/needed |
| <input type="checkbox"/> Do not trust service provider | <input type="checkbox"/> Other (Describe): _____ |
- ☐ N/A

16a. Were you previously referred to another service by a CHW? ☐ Yes ☐ No (go to question 17)

16b. List service 3 _____

16c. Were you able to access [service 3]?

- ☐ Yes
- ☐ No – b. If no, what were the reasons for not following through with referred service?
- | | |
|--|--|
| <input type="checkbox"/> Too far | <input type="checkbox"/> Lack of time |
| <input type="checkbox"/> Transportation issues | <input type="checkbox"/> Service no longer wanted/needed |
| <input type="checkbox"/> Do not trust service provider | <input type="checkbox"/> Other (Describe): _____ |
- ☐ N/A

ADDITIONAL SERVICES/ASSISTANCE REQUESTED:

17. Do you need any additional services?

- ☐ No, participant did not request services
- ☐ Yes, participant requested services
- If yes, describe request and assistance provided by the CHW, as well as any necessary next steps or follow-up:

FOLLOW-UP PLAN

Next meeting scheduled for: Date: _____ Time: _____ ☐ By Phone ☐ In-Person Location: _____

Length of Encounter/Call: _____ minutes

